NETWORK HEALTH

June 15, 2011

Seena Carrington
Acting Commissioner
Massachusetts Division of Health Care Policy and Finance
Two Boylston Street
Boston, MA 02116

Dear Commissioner Carrington:

Thank you for the opportunity to offer testimony regarding Network Health's cost and utilization experience in both our MassHealth and Commonwealth Care lines of business. Since the statewide data contained in the DHCFP's recent reports included only commercially insured individuals, we are pleased to be able to testify on trends we experienced in the two publically subsidized programs that we administer.

I am legally authorized and empowered to represent Network Health for the purposes of this testimony.

I attest that, to the best of my knowledge and belief, the attached testimony is true and accurate.

Submitted under the pains and penalties of perjury on this 15th day of June, 2011.

Network Health, Inc.

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Medicaid HMO

Network Health's Testimony
to the Massachusetts Division of Health Care Policy and Finance
June 15, 2011

Response to DHCFP Questions for Written Testimony

1. **After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends*, please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.**

   Brief Summary: Although our experience is limited to the MassHealth and Commonwealth Care programs, we have had similar experience relating to:
   1) extreme cost variances among providers for similar services, and
   2) a disproportionate share of our membership receiving care in higher cost institutions.

   Response: Our experience relative to price variation and concentration of services has been very similar. There is great variation in the cost of services based on where that service is provided. Additionally, we have found that our members disproportionately use high cost hospitals, despite the fact that there are high value (high-quality, low-cost) alternatives in most geographic markets.

   The Medicaid SPAD (Standard Payment Amount Per Discharge) rates set by EOHHS vary by facility with a high cost facility receiving a payment 180% greater than a low cost facility. While these rates may attempt to keep payment rates relatively narrow across providers, some hospitals insist on receiving payment based on a percentage of charge (PAF) methodology unrelated to the SPAD rates while most others require contracted rates at a level above the Medicaid rates. To highlight rate differences for similar inpatient stays at different hospitals, Network Health examined its maternity utilization for CY2010 to determine both the relative use of teaching hospitals among its members for childbirth and the range of average cost per admission paid for uncomplicated vaginal deliveries – one of Network Health's most common hospital procedures. In CY2010, rates paid by Network Health for uncomplicated vaginal deliveries ranged from $2,624 to $9,306 per case, a variation of 254%. The average cost per case for an uncomplicated vaginal delivery was 62% higher in CY2010 at teaching facilities than at all other facilities. The percentage of uncomplicated vaginal births occurring at teaching facilities continued to rise for Network Health reaching 43% in CY2010 and accounting for 55% of the costs for such births. Because Network Health does not have a classification system to assess data by severity level as was done in the DCHFP report, we focused on uncomplicated deliveries because we assumed similar severity levels for those diagnoses across facilities. Without the ability to group services and account for differences in severity, we are unable to readily highlight differences between payments at different facilities by service.

   In recent years, we have actively worked to reduce the cost per unit at the highest paid hospitals through contract negotiations in addition to reducing utilization at these facilities through referral management. As a result, we have realized a decline in the cost PMPM paid to these hospitals.

   Network Health's experience is limited to the publicly-funded programs of MassHealth and Commonwealth Care. Because of State and CMS regulations, health plans in the Medicaid/subsidized market are not permitted to utilize benefit design or tiered networks to move services to preferred providers. Thus, additional tools are needed (either through the State's member assignment rules or other innovative policies) to obtain savings by redirecting care from high cost sites to more efficient providers.

2. **We found that - when adjusted for all factors (benefits, demographics, geography, etc.) – small businesses are paying more for premiums and have experienced sharper growth in rates than mid-size and large employers. Is this finding consistent with your organization's experience? Please comment on why you think this is happening and what can be done to assist small employers.**

   Brief Summary: Not applicable.

   Response: Network Health's experience is limited to the publicly funded programs of MassHealth and Commonwealth Care.

3. **What are some of the non-medical drivers (not related to health care prices or utilization) that have led to premium growth in recent years? What is your organization doing to minimize their impact on premium costs?**

Brief Summary: The growth of administrative costs, in particular the IT and operational costs created by recent regulatory requirements, have contributed, to a limited extent, to the increase in premium growth in recent years. Network Health has consistently kept its administrative costs below market levels.

Response: While not as significant a factor as medical cost growth, the growth of administrative expenses has contributed to the increase in premium growth in recent years. A key factor has been the IT and operational investments required to comply with recent regulatory requirements around privacy and security. Additionally, there are material costs associated with compliance in implementing 5010 and ICD-10 coding changes.

To control medical costs and improve quality outcomes, Network Health has increased its investments in care management, particularly for targeted high risk populations. These investments may also be characterized as medical expenses, although we account for these in our administrative costs. For example, over the last two years, we have improved our ability to identify high-risk patients subject to clinical intervention and have developed more robust outreach programs and clinical supports around transition of care and other outpatient care management. We believe that these investments have contributed to our favorable medical trends and improved quality measures.

Despite increases in administrative investments, Network Health has continued to maintain one of the lowest administrative cost ratios in Massachusetts. Over the past few years, Network Health's administrative cost ratio has decreased from 6.6% to 5.9% of premium revenue.

4. What systemic actions do you think are necessary to mitigate health care cost growth and health insurance premium growth in Massachusetts?

Brief Summary: High costs and premium growth result from multiple factors including the complexity of the delivery and financing systems as well as the interrelated issues of system inefficiencies and waste. Actions to mitigate cost growth must be multi-pronged with concerted action by all stakeholders, including payers, providers, consumers, purchasers, and government regulators. For example, meaningful consumer engagement as well as systemic change in the way that care is delivered is essential. Importantly, improved quality and reduced costs are two sides of the same coin – there is not an inherent conflict in delivering both. On the contrary, the most meaningful approach to reducing costs is to improve quality – i.e., delivering the right care at the right time at the right place.

Response: Solutions must be multi-faceted and target the various causes of the problem.

Consumer engagement – Increasing the consumer's engagement in behaviors that impact his or her health status and decision-making is one important area of focus. In the commercial market, activities to promote greater consumer engagement often focus on incentives and disincentives. For example, commercial plans have increasingly turned to value-based benefit designs that may create more price sensitivity around provider choice (such as tiered networks with co-pay variances) or incent desired wellness behaviors and disincent costlier and less appropriate procedures or sites of services (e.g., emergency department copays).

In the Medicaid space, because benefits are mandated by CMS regulations, there is less flexibility for plans to engage consumers through value-based benefit design. Moreover, for consumers at the lower end of the income scale, any non-minimal cost-sharing requirement would likely result in inadequate utilization of care or uncollectible debt.

Therefore, Network Health recommends these additional approaches to increase consumer engagement, particularly for the public-program enrollees:

a) Enhancing the role of the PCP – Through an improved PCP/patient relationship, patients will more likely adhere to medical advice, seek appropriate care in appropriate settings, and have a trusted partner to understand and improve their own health. Related to this, the patient-centered medical home (PCMH) model is a positive development that should ultimately reduce costs by improving outcomes through increased consumer engagement and less fragmented care.

b) Leveraging the role of the Health Plan – Plans have an important role in engaging the consumer in behavior change and in making informed decisions. For example, for the general population, this role includes educating members about the relative value (cost and quality) of network providers and supporting wellness programs and healthy behaviors. For members with chronic diseases or other more intensive medical needs, the health plan can also provide health coaching and outreach services to educate and engage members in self-directed care.

c) Utilizing the tools of the Purchaser and the Commonwealth – For public programs, the Commonwealth can play a greater role in education around costs and high value care and can, as a purchaser, implement rules reducing member "churn", and directing member assignment to promote consumer engagement as well as reward plans that are more successful in these areas. In addition, the Commonwealth can continue to support and develop new models of patient-centered care as well as aggregate and disseminate cost and quality information that is foundational for informed choice.

Provider Engagement –Consumer engagement is best catalyzed in conjunction with provider engagement activities and incentives. Accordingly, there are great opportunities for changing provider behaviors around inappropriate utilization, improved safety and quality, and reduction of waste. By investing in improved provider performance and rewarding outcomes rather than volume, improvements do result.

While much has been written about payment reform and ACO development, it is still too early for us to report on our experience with alternative payment models. Still, we fully endorse the concepts behind payment reform that incorporate a) transformation in the clinical model of care delivery (i.e., less fragmented, better coordinated team-based care) and b) transformation in how such care is financed (e.g., global payments, shared savings). Both the clinical changes and the financing structure are critical drivers of high value care. Finally, there can be little question that unit cost variation – whether it is primarily a result of market power or higher delivery system costs that are passed through to the purchaser – must be more closely examined and higher variances should be reduced to the extent possible, taking into account appropriate variations due to factors that society values (e.g., care for the sickest populations, teaching and research costs, free care burden).

5. What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians, and other professionals? Please explain each factor and rank them in the order of impact on negotiated rates.

Brief Summary: As a Medicaid Managed Care Organization (MMCO), Network Health develops its payment rates using the Massachusetts Medicaid fee schedules which include the SPAD (Standard Payment Amount Per Discharge) for facility inpatient services, PAPE (Payment Amount Per Episode) for the facility outpatient services, and the general Medicaid fee schedule for professional services. We use these rates as the starting point in our negotiations. However, providers generally assert that 100% of Medicaid reimbursement is insufficient to cover their costs. Since the beginning of the MMCO Program, reimbursing providers at a negotiated percentage over the Medicaid rates has been required to achieve adequate network access for enrollees.

Response: While many providers accept a percentage above the base rate, those that enjoy geographic market power, offer specialty services, and carry a strong brand or reputation often demand higher rates. These factors also become critical to our ability to successfully negotiate fair and reasonable rates. In many geographic areas, hospitals are the 'only game in town' and, therefore, they leverage their market dominance to either selectively contract or extract higher contract rates. In such cases, Network Health has been forced to pay higher rates in order to retain service areas as required under its contracts with both MassHealth and the Connector.

Medicaid rates paid directly to providers by MassHealth for services to beneficiaries who are not enrolled in MMCOs are set by MassHealth on an annual basis. It is assumed that the base Medicaid payment level set by MassHealth provides an appropriate starting point for the relative cost variance of the contracted hospitals because this base Medicaid payment is calculated by EOHHS based upon case mix and cost factors of the respective hospitals. To the extent possible, Network Health utilizes this same reimbursement methodology, although a limited number of the more highly leveraged hospitals insist on being paid at a percentage of charge (PAF) methodology. We also use this methodology for our Commonwealth Care product, with some adjustments in a limited number of contracts for case mix differences. This is generally the standard in the market as well. That said, we recommend that MassHealth review its payment methodology for opportunities for improvement. The nature of this methodology maintains the status quo in underlying hospital cost variation and does not have the advantages that DRG methodology has in more refined levels of payments based upon treatment severity.

While MassHealth pays physicians based upon one Medicaid professional fee schedule (in contrast to the hospital specific SPAD and PAPE rates), the fees for professional services are often incorporated into highly leveraged contracts and may be negotiated by PHOs to include both physician and hospital services. One important difference in Medicaid/subsidized networks is the prominence of community health centers. The Medicaid fee schedule includes unique community health center rates and codes that provide reimbursement for a comprehensive set of services. Network Health also pays at a percentage above these rates, utilizing this methodology, under its contracts with community health centers. These rates provide for higher level of PCP reimbursement than that received by independent PCPs.

We continue to actively engage providers in discussions around appropriate reimbursement and to obtain lower unit costs through a variety of contracting strategies. These discussions incorporate the use of available data from Medicaid Cost Reports, MHQP, and DHCFP to help evaluate quality and cost. We have seen some shift in the last two years to a more reasonable contracting approach from some providers who had previously used their market power more assertively to achieve greater rate disparities. This shift may be due to a) more aggressive contracting by all the MMCOs, b) a recognition of political consequences relating to outlier rates for public programs, and/or c) greater recognition on the part of providers of their responsibility in improving the affordability of health care.

6. **Is there a material difference in how you approach contracts when you are contracting with a health care system vs. contracting with organizations representing a single facility or provider group?**

   Brief Summary: Market leverage continues to play a significant role in the negotiations between providers and payers, even in the public market. Systems have greater leverage than small organizations and groups; this leverage is reflected in the fee-for-service rates agreed to by the parties.

   Response: There are unique challenges to negotiating with health care systems. Systems that offer a full breath of services and dominance of geography continue to seek higher rates. There are, however, benefits to contracting with systems rather than smaller groups. Contracting at a system level enables plans such as Network Health to bring a full network of services under a single contract instead of working to building a network that meets access and availability standards one provider or group at a time. Also, there is an opportunity to leverage patient volume for provider engagement which can be manifest in new payment models (e.g., shared savings and global payments) and in clinical and performance improvement interventions.

   Working with larger systems can be a double-edged sword. On one hand, the larger the system, the greater the opportunity for the provider to extract rates more favorable to the system. On the other hand, there are opportunities for meaningful performance improvement activities in a larger system, particularly one that is interested in investing in such activities. Indeed, there are economies of scale relating to clinical interventions that are less feasible in smaller group practices. For example, larger systems tend to have more robust electronic medical records and other clinical infrastructure around care management. Furthermore, performance measures are only useful when there is sufficient volume to reliably measure patterns and trends. This last point is particularly critical to moving to financing models that reward results.

7. **We understand that certain systems demand higher rates because of geographic isolation, specialty practice and reputation. Please explain your understanding of this dynamic.**

   Brief Summary: While the demands for higher rates continue, MMCO rate re-negotiations and membership shifts have begun to change some of this dynamic in select markets.

   Response: Network Health has experienced the demand for higher rates in both metropolitan areas and rural markets. While the demand for higher rates continues, MMCO rate re-negotiations and membership shifts have begun to change some of this dynamic in select markets. There remain some markets where Network Health is affected by this practice; we have made difficult decisions to limit service area coverage in these areas because we could not agree to higher rates or were excluded as a result of preferred relationships.

   Providers that offer specialty services and are in demand by consumers create additional challenges when contracting. In many instances, it is necessary for us to include these providers in our network at higher rates because of uniqueness of service and reputation. Depending on the specialty service, Network Health has implemented operational processes to redirect some services to comparable facilities while maintaining appropriate access for our members.

8. **What quality measures does your organization use to assess quality outcomes by provider? What incentives or consequences are there for providers based upon their performance?**

   Brief Summary: Network Health provides a range of quality performance data to providers. Other than non-payment for certain limited categories of events or services that are markers for quality concerns, we do not have specific payment incentives for quality results.

   Response: Network Health delivers provider performance data to primary care groups with 300 or more Network Health members. Performance measures include HEDIS-based quality measures, PCP/ED visit ratios, and percentages of generic prescriptions. We are currently implementing a series of flexible Web-based reports through the use of the MedVentive software. These reports will include comparative HEDIS results, hi-risk patient identification using risk score analytics,

efficiency metrics using episode treatment groups, and pharmacy prescribing patterns and interchange opportunity identification. This performance analytics system is currently being piloted with one large hospital/physician organization and one community health center, and will be rolled out to our full provider network during the next nine months. Currently, our provider performance data is informational; there are no incentives or consequences for quality performance in these areas.

Network Health also regularly monitors for potential "never events" and follows state guidelines regarding non-payment for such events and associated additional costs. We are also preparing to implement non-payment for avoidable readmissions based on the EOHHS definitions which are expected soon. Additionally, we are closely following implementation of the new regulations anticipated relative to Provider Preventable Conditions (PPCs).

9. What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

Brief Summary: To achieve high value care, payment should relate to cost and quality.

Response: We support the concept of correlating financial incentives to the delivery of higher quality of care. The challenge, however, is in the measurement and execution. Appropriate risk adjustment is a necessary component of any measure of quality (and cost). We recommend that broad, comprehensive measures of quality are utilized, rather than those with a limited focus. Overall, the concept of a threshold level of quality performance is reasonable, below which payment withholds may be used and above which higher payments may occur. In most circumstances the spread must be sufficient to be meaningful but must also be easily administered.

We believe that quality measures can and should be improved. It is most reasonable to use a subset of currently available and widely collected quality data, appropriate to the setting, such as HEDIS measures, CMS quality measures, or DPH reported measures. For example,

- inpatient care paths must be developed and tracked.
- for specialists, efficiency measures combined with access and patient satisfaction can be valuable.
- for primary care, access, ED visits, and other measures of patient satisfaction can also be employed in addition to a subset of HEDIS measures.

Avoidable readmissions as well as avoidable ED utilization are also reasonable quality measures.

Public programs must increasingly focus on measures which effectively capture the integration of primary care and behavioral health. Data available through the all payer claims database can reduce administrative burden and provide scale to prevent small samples from skewing the data.

Once quality measures are selected, it is critical to apply continual improvement principles to the measurement itself.

10. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

Brief Summary: Network Health has also found that a large portion of patient volume is clustered in the most expensive providers.

Response: Our data indicate that a high proportion of inpatient services is being provided at expensive locations (e.g., teaching hospitals) despite the availability of lower cost alternatives. We attribute this distribution to a combination of consumer choice (which is frequently based upon brand/reputation) and provider referral patterns.

During CY2005 – CY2010 teaching hospitals represented approximately 59 – 63% of Network Health's total inpatient costs and 39 - 42% of total inpatient admissions. In response to this problem, Network Health tightened its referral policies around pediatric hospital and specialty care in order to better manage where services are delivered. Since implementing our Preferred Pediatric Program (as described in our response to question 13) we have tracked nearly $5M in savings relative to projected costs during FY10. Thus far in FY11 we are tracking over $1.2M in savings attributable to this redirection.

11. What tools should be made available to consumers to make them more prudent purchasers of health care?

Brief Summary: Consumer education about cost and quality is a key tool

Response: We endorse increased transparency in cost and quality. Moreover, we support a multi-faceted, multi-media approach to the delivery of actionable information to the consumer.

Today, there is a wealth of information available on the internet that sets out comparable prices and quality metrics. We recognize that websites, such as the website developed by the Massachusetts Health Care Quality and Cost Council, are important tools for consumers to learn about cost and quality of care in Massachusetts.

While data is available, we believe more should be done to educate consumers and providers about availability of information, in conjunction with providing user-friendly tools to assist consumers in assessing and acting upon this information. Lack of knowledge of or accessibility to this data limits its usefulness. Accessibility may be impaired by a range of socioeconomic or medical factors including limited English proficiency and limited access to the internet. Additionally, even consumers who successfully access this information will likely need help in translating how this relates to their own health care choices. In addition to these general web-based tools, we recommend insurer-specific information be made available to consumers, either directly from the health plan or by requiring the providers themselves to post or share information about their relative pricing and quality. Such data would be particularly useful for providing further transparency regarding the higher cost providers. Additionally, requiring high cost providers to include disclaimers in their own marketing and advertising materials and other patient-facing collateral could be informative. Of course, this initiative can be successful, only if consumers are able to understand the whole picture – both from a comparative cost and quality perspective.

12. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers for different services) from your organization's perspective? What about complete quality transparency?

Brief Summary: Price comparisons should always be published in conjunction with quality information. Price transparency works best when directly associated with 1) meaningful outcomes data and 2) consumer incentives to choose the lower cost providers who offer equal or higher quality.

Response: Focusing on price alone will likely not achieve desired change in consumer behavior unless we also dispel the common misperception that higher cost correlates to higher quality. For public programs where member price incentives are, by law, extremely limited, the potential for misinterpretation is even greater. Additionally, the combination of 'price and quality transparency' coupled with broader public awareness campaigns relating to the harms caused by overuse or inappropriate use of medical resources (including avoidable ED utilization, high cost imaging, and poly pharmacy abuse) may make a difference in consumer behavior and choice. Consumers at all income levels have reason to care about the policy implications of excessive health care costs. Simply put, dollars unnecessarily spent on health care cannot be spent on job creation or improving schools. The recognition of the true costs to the community is a potentially potent concept in supporting behavior change.

Additionally, there is reason to be cautious about complete price transparency relating to private contract negotiations among payers and providers. While it is likely that, with greater transparency, there will be less rate variation in negotiated agreements, one fear is that lower paid providers will have more ammunition to extract higher prices when their contracts are renegotiated. Presumably there will be arguments in both directions to move prices, and that the pressure on higher-priced providers that results from transparency will outweigh any such increases for lower-priced providers.

13. What methods, if any, does your organization use to encourage consumers to use high value (high-quality, low-cost) providers? What has been the effectiveness of these actions?

Brief Summary: Network Health encourages consumers to use high value providers. Initiatives such as our Preferred Pediatric Program and our new limited network have been successful.

Response: In 2009, Network Health instituted a Preferred Pediatric Program for its MassHealth product in response to the substantially higher cost of care in its contracted pediatric academic facility. As part of this program, Network Health implemented a prior authorization requirement for outpatient, specialty, and non-emergent inpatient admissions. Referrals were approved for continuity of care reasons or because such services were not available at other institutions. All other services were redirected to lower cost providers. (We also allowed members with affiliated PCPs to access hospital and specialty care without prior authorization.) Since implementing the program, Network Health tracked over $6M in savings

relative to projected costs without this program. Additionally, there has been minimal member disruption relating to this program. We considers this initiative a success from both a quality and cost perspective.

Secondly, to further reduce the costs of providing quality care to its members, Network Health developed a high-value network design which will take effect July 1, 2011 for the Commonwealth Care product only. This initiative enabled us to deliver network cost savings by limiting use of higher cost providers and re-negotiating contract rates with certain other providers seeking to remain in our Commonwealth Care network. The result was approximately a 10% reduction in calculated costs, based upon projected utilization shifts. This reduction is consistent with the results of the DHCFP report generally, in reflecting the greatest opportunity for cost mitigation in the short term. Our "limited" network design was only feasible because the purchaser (in this case the Commonwealth) passed the savings on to members who pay a portion of their premiums out-of-pocket, and also set up other membership growth rules to reward the low cost payer. There are currently no similar rules on the MassHealth contract to incent health plans to offer such a "limited" network product.

14. Does your organization currently offer limited or tiered network plans? If so, please describe the level of interest and/ or participation from groups and individuals, as well as any feedback you are aware of from those participating.

Brief Summary: Effective July 2011, we will implement a high-value network for our FY12 Commonwealth Care product. We anticipate certain enrollees will be choose Network Health over other health plans because of direct cost savings relating to our new "limited" network design.

Response: As set forth in our response to question #13, Network Health is offering a high-value network for its FY12 Commonwealth Care product. Although we do not have participation rates yet, as our "limited" product will be implemented effective July 2011, we anticipate that the premium reduction will be a major draw for Commonwealth Care members in two major segments:

1) those whose providers are in Network Health's network; and
2) those for whom price is a greater consideration than a specific provider relationship.

a. Please also provide premium differences between the limited/ tiered plans and comparable plans that have more open networks.

Network Health's premiums paid by the consumer are between $21 and $81 lower per month than plans with more open networks (an additional differential is paid by the Commonwealth). To individuals earning under 300% of the federal poverty level, these differentials are substantial. We do not have sufficient data from other health plans to know what portion of the cost differential can be attributed to the difference in network design versus other cost factors.

b. Please also provide information about how you market and explain these options to employers and consumers.

In a recent marketing campaign, we included the message that "Our members come first." Network Health is marketing its high-value position directly to consumers through a range of mass media. Drawing on our belief that consumer engagement is a critical factor in managing costs, we use our open enrollment advertising campaign to explain directly to consumers that we have lowered costs while maintaining quality. To ensure consumers understand their choices and the trade-offs they may need to make, we are educating members and potential members about the participating providers through our Web site as well as through member mailings with specific provider network information. We also train our customer service representatives to respond to member inquiries.

Additionally, the Connector plays a key role in educating Commonwealth Care enrollees on their options and the potential trade-offs between premiums and available providers.

15. Please respond to the trends presented in Table 20. The total medical spending portion of premiums appeared to slow for 2009-2010 as compared to previous years. If your organization also experienced slowed medical spending, please explain the underlying factors. If your organization did not experience the slow-down in trends, please explain why your organization differed from the average.

Brief Summary: As compared to previous years, our total medical spending portion of premiums slowed. In CY2009 to CY2010, Network Health bent the cost curve trend driven by a slowing of utilization increases.

Response: From CY2009 to CY2010, Network Health has seen a slowing in medical expense PMPM trends of 0.2%. The decreases in cost per unit cancelled out the increase in utilization realized from CY2009 to CY2010. In general, utilization has acted as the primary driver of the total cost PMPM increases from CY2006 to CY2010. In CY2009 to CY2010 Network Health

has bent the cost curve trend by a slowing of utilization increases. The increase in utilization from CY2009 to CY2010 was 4.9% compared with a utilization increase of 20.0% from CY2008 to CY2009. (Please note that 2008 to 2009 also reflected population changes). This decrease in PMPM utilization trends coupled with continued decreases in cost per unit trends resulted in total medical expense PMPM cost remaining level from CY2009 to CY2010.

Our management actions have also had a material impact on cost trends from CY2009 to CY2010. Specifically, Network Health made material improvements in its pharmacy benefit manager contract, enhanced its medical management programs, and improved its payment recoveries.

16. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What has been you experience and the results in terms of quality performance and cost mitigation?

Brief Summary: Network Health has entered into one global payment contract. Discussions with several other providers on value-based payment models are in the early stages; our goal is to move more of our provider network into these types of arrangements over the next few years. We believe that we will see increased medical cost savings and improved quality outcomes by partnering with providers around performance improvement opportunities and engaging providers to change inefficient and fragmented care delivery.

Response: Network Health has entered into discussions with several key providers to move from a fee-for-service payment methodology to an alternative payment methodology that would share risk and align incentives. Currently, these types of arrangements range from a shared savings model, to a PMPM budgeted medical expense target with both up-side and down-side risk sharing, to a global payment model based upon al percent of premium methodology, with shared surplus and deficit sharing.

We have are just completing our first year of experience with the budgeted global payment contract, it is still too early to quantify the effects of this new payment model on cost and quality improvement. However, the alignment of incentives and the nature of the collaboration have led to significantly more focused efforts from both parties to improve quality and manage costs. These efforts include redirecting referrals from higher cost institutions to more appropriate settings, reducing ED utilization, improving care coordination for high-risk patients, reducing unwarranted readmissions and developing other concrete steps to improve care.

17. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

Brief Summary: Low acuity/non emergent (LANE) emergency department (ED) utilization remains a significant problem. Reducing such visits also continues to be a difficult task. Additional cost drivers include high cost technologies and increasing pharmaceutical costs.

Response: ED utilization, as we outlined in our testimony last year, continues to present a significant problem regarding inappropriate utilization of resources, particularly for MassHealth and Commonwealth Care enrollees. Reducing these LANE and other potentially avoidable visits remains a difficult task.

MMCOs do not have the same tools available to manage these costs as are available to commercial health plans; in particular, there is no flexibility around benefit design and, thus, no financial incentive available to engage members to reduce inappropriate ED use. The shorter enrollment duration of MassHealth and Commonwealth Care members due to "churn" further frustrates patient education and care management for the general Medicaid population, as compared to the commercial insureds. In addition, federal EMTALA laws restrict the discretion of hospitals to limit services to patients who present at the ED, even if such care would be more appropriately provided at a lower cost setting. A concerted effort is needed from the State and all stakeholders to develop creative solutions to protect patient safety while driving non acute care from the ED.

Inappropriate utilization remains a well-documented cost driver and includes inappropriate hospitalization due to readmissions, lack of coordinated care, and misuse or non-adherence to medication prescriptions as well as other costs attributed to poor quality and overutilization and underutilization of care. Traditionally, such cost drivers are the focus of MMCO management and disease management programs.

Consequently, it would also be useful for the State to examine whether improved access and increased consumer engagement with primary care practices, including increased support for the "Medical Home Model", can drive down the cost of care in a measureable way, e.g. reduced LANE visits, reduced hospital days and admits, and reduced complications and improved health outcomes.

Additional cost drivers include higher new technology costs, driven by both increased availability and consumer pressure for increased use. For example, the demand for increased genetic testing to identify disease risk as well as to guide therapies is likely to increase dramatically.

Pharmaceutical spending growth has been a major contributor to increased health care costs in all sectors, including Medicaid. Specifically, we have seen rising costs for specialty pharmacology including biologics and oncology therapies as well as orphan drugs.

18. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

Brief Summary: While Network Health has mitigated cost trends through a range of targeted management activities, significant barriers remain, particularly relating to market leverage and the current fee-for-service payment system.

Response: Network Health has had significant success in mitigating cost trends through management activities relating to contracting and medical management as well as other efforts toward reducing inappropriate payments for medical services. There, however, remain significant barriers to successful management of cost trends due to failures of the market to keep unit costs fair and reasonable. In addition, there is evidence that rate regulation that maintains historical inequities is not an appropriate solution and when applied to only one business segment (e.g., PCC Medicaid population) leads to cost shifting to the non-regulated business (e.g., MMCO Medicaid population and commercial business).

Network Health also believes that the current fee-for-service payment system incentivizes physicians and hospitals to provide services that are frequently inappropriate, and results in lower quality of care and higher overall medical costs. Just how much waste can be eliminated by reforming payment models and creating ACOs is difficult to estimate. We think it is equally important to focus on the underlying base costs of providing care and the variations in costs, practice patterns and outcomes among practices, delivery systems and geographic markets.

Network Health's Response to AGO Questions for Written Testimony

1) **Please explain and submit a summary table showing the range of your aggregate health status adjusted relative commercial prices or payments from 2009-2010 for each acute care hospital and large physician group in Massachusetts (i.e., physicians who contract through a PHO, IPA, multi-specialty group, or other group arrangement). If the aggregate health status adjusted relative commercial prices or payments from 2009-2010 that you submitted to the Office of the Attorney General differ from the information provided to the Division of Health Care Finance and Policy, please explain the differences and why such differences exist.**

Brief Summary: The data being submitted to the Office of Attorney General does not differ from the information provided to the Division of Health Care Finance and Policy.

Response: The aggregate, outpatient health status adjusted relative prices from CY2009-CY2010 for each acute care hospital in Massachusetts are set forth in *Attachment A*-1: *Relative Price - OP Hosp 2009* and *Attachment A*-2: *Relative Price - OP Hosp 2010*. These data do not differ from those submitted to DHCFP, except mental health and rehabilitation hospitals included in the submission to DHCFP have been excluded per AGO instructions. This data was produced in accordance with the specifications and methodology described in the regulations and data manuals published at http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_5_23.pdf.

Relative Price information regarding large physician organizations is attached in Attachment A-3: *Relative Price PhysGroup 2009*.

Relative Price information regarding inpatient hospital costs is currently not available as Network Health does not have the ability to assign the DRGs to inpatient hospital stays necessary to calculate the health status adjusted inpatient relative prices. Network Health is working closely with DHCFP; DHCFP has agreed to assist us with the DRG grouping until we gain the capacity to run DRGs ourselves. We anticipate having such capacity in the fall of 2011. We are currently working on file formats for data exchange with DHCFP, so that DHCFP may assign DRGs to our inpatient claims and we can complete the inpatient relative price reporting before this fall.

2) **Please explain and submit documents to support how you quantify the amount of, and adjust the amount of, risk being shifted to providers in your network, including risk on self insured as well as fully insured plans. Include in your response any distinction you make between performance and insurance risk.**

Brief Summary: Network Health is still in the early phases of risk-sharing arrangements with its network providers.

Response: To date, we have had a year's experience under a budgeted global payment model with one delivery system and are currently in active discussions with several other systems for risk-sharing or shared savings arrangements. The current arrangement is with a multi-hospital system that employs approximately 400 physicians and serves approximately 15,000 of Network Health's membership, based upon PCP-assignment.

Under the budgeted global payment model, Network Health and the delivery system agreed on an allocation of the premium dollars received by Network Health for members who are assigned to the system's PCPs for all covered services – whether or not such services are provided within the system. The allocated medical premium is then compared to actual medical expenses at the close of the year, and there is 50/50 risk-sharing between the parties for any surplus or deficit of medical costs against the allocated portion of the premiums. Reinsurance and stop-loss coverage is also provided for under this arrangement, based upon the programs in which Network Health participates.

The amount of risk being shifted to the providers under this arrangement is determined to be appropriate because the size of the population is sufficiently large to make reasonable actuarial projections of future costs. Furthermore, the parties agree that there are sufficient tools to enable performance improvement through a collaborative effort around the use of EMR, data analytics, risk-adjustment, predictive modeling, clinical redesign initiatives and the like. Moreover, the parties are sharing risk and not simply "shifting" risk, so this enables us to mitigate any financial harm to the provider and to have aligned incentives for success.

3) **Please explain and submit documents to support how you quantify the total amount that you negotiate to pay at-risk providers on their total commercial business including HMO and PPO, risk and fee-for-service payments. Include in your response how you value any various aspects of provider risk contracts (e.g., carve-outs for certain services such as behavioral health or high cost pharmaceuticals; attachment points beyond which services are not chargeable against the risk budget; quality payments; fees; and other similar negotiated aspects of the contract).**

Brief Summary: Not applicable.

Response: Network Health has no commercial business.

4) **Please explain and submit a summary table showing the range of health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2009-2010 for each Massachusetts provider in your network who contracts through a PHO, IPA, multi-specialty group, or other group arrangement, with each provider identified by whether it was paid based on a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/ or deficit charged to a provider. "Fully- loaded" means inclusive of all administrative, medical management, and other supplemental payments, including but not limited to bonuses, grants, infrastructure funding, and reinsurance recoveries. If the health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2009-2010 that you submitted to the Office of the Attorney General differ from the information provided to the Division of Health Care Finance and Policy, please explain the differences and why such differences exist.**

Brief Summary: The data being submitted to the Office of Attorney General does not differ from the information provided to the Division of Health care Finance and Policy.

Response: The health status adjusted, fully-loaded total medical expenses paid by Network Health, on a PMPM basis, from CY2009-CY2010, for each Massachusetts provider in our network who contracts through a PHO, IPA, multi-specialty group arrangement is detailed in Attachment A.4: *Total Medical Expense PMPM 2009* and Attachment A.5: *Total Medical Expense PMPM 2010*. The data was produced in accordance with the specifications and methodology described in the regulations and data manuals published at http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_5_23.pdf.

Each provider is identified as not paid based on a negotiated PMPM amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider. "Fully loaded" means inclusive of all administrative, medical management, and other supplemental payments, including bonuses, grants, and infrastructure funding. The current Network Health data is absent reinsurance recoveries, which were inadvertently omitted and will be submitted to the state by mid-July.

The health status-adjusted fully-loaded total medical expenses Network Health paid on a PMPM basis from CY 2009- CY 2010, submitted to the Office of the Attorney General does not differ from the information provider to DHCFP.

5) **Please explain and submit a summary table showing your premium trends from 2005 to 2010 with details on how much of your premium trend resulted from increases in administrative costs, reserve practices, and medical trend, including the proportion of medical trend that resulted from (1) health care provider unit price increases, (2) changes in utilization, and (3) all other factors, such as changes in mix of services, mix of location of services, member demographics, and plan design. Please explain how you track each of these components with respect to providers in your network who are paid on a per member per month budget arrangement (whether at-risk or "upside only").**

Brief Summary: While in recent years utilization has been the main driver of cost trends, both of Network Health's lines of business, MassHealth and Commonwealth Care, saw slowing utilization trends beginning in CY2009 to CY2010.

Response: As set forth in *Attachment B* (*Analysis of Yearly Medical Expense*) Network Health's medical expense PMPM increased 37.4% between CY2005 and CY2010. Utilization was the main driver with a rise of 33.9% from CY2005 to CY2010. During the same time period cost per unit increased only 2.6%. While in recent years utilization has been the main driver of cost trends, both Network Health's lines of business, MassHealth and Commonwealth Care, saw slowing utilization trends beginning in CY2009 to CY2010.

Population changes also had an impact on cost trends during between CY2005 and CY2010. For example, the inception of the Commonwealth Care program and changes within that population in subsequent years as well as the addition of RCVII members and changes in the RCII member pool for the MassHealth population in 2010.

Network Health has not seen a material shift in its distribution of services among teaching hospitals and non-teaching hospitals; we do not attribute our cost increases to patients shift in service location.

6) Please explain and submit supporting documents that show what affect, if any, limited network or tiered products have had on premium trend.

Brief Summary: To reduce premiums for members with state subsidized health care, Network Health recently created a more "limited" network for its Commonwealth Care product, relative to the full network that had previously been offered. Based upon projected cost differentials under this new network design, we were able to offer premiums approximately 10% lower than we would otherwise offer if no changes had been made to our network.

Response: Network Health has recently created a limited network for its Commonwealth Care product to offer a lower cost alternative and gain membership. The basis for this limited network was consistent with the findings of the AG report on disparity of health care costs across providers. Network Health identified its high value providers by geographic areas. We were also willing to renegotiate rates with excluded providers and move them into the high value classification. We were able to reduce premiums by approximately 10% based on this redesign.

7) Please provide a summary table showing your membership by year from 2005-2010, including: (1) what percent of your members are enrolled in HMO/POS PPO, and indemnity, (2) within each product category (HMO/POS, PPO and indemnity), what percent of your members are fully-insured, self-insured, or other, and (3) within each product category (HMO/POS, PPO and indemnity), what percent of your members are enrolled in tiered or limited network products.

Brief Summary: Not applicable.

Response: Network Health's products are limited to MassHealth and Commonwealth Care; both are HMO models.

8) Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including factors such as the provider's solvency, historical experience with risk payments, size, organizational structure, ways in which you adjust the provider risk budgets, and any other factor.

Brief Summary: Network Health considers multiple factors to evaluate the capacity of a provider to participate in a risk contract. We also offer shared-savings models for which more of our providers qualify.

Response: An important factor to determine – as we evaluate the capacity for participation in a risk contract – is total Network Health membership. Ensuring that membership levels can support a risk contract is foundational to our assessment. There is debate in the market regarding minimum numbers, and different populations may require different threshold levels.

We currently use as a guide a minimum standard of 5,000 Network Health enrollees assigned to PCPs affiliated with the identified system. Additional considerations include whether the system a) has experience with similar models with other payers, b) has a broad range of services included within their own four walls, c) has experience with managed care; and d) is financially able to bear risk in a deficit sharing arrangement. As important is the delivery system's engagement in performance improvement activities and willingness to incur infrastructure investments for its total patient population. Network Health is willing to contract with hospital/physician systems or physician groups acting alone (including community health centers), depending on our evaluation of their qualifications.

Network Health has developed an ACO-development "toolkit" approach allowing us to partner with providers along the continuum of ACO development who have an interest in moving into value-based contracting. Our proprietary approach includes a) clear identification of the PCP-based population, b) a thorough analytic review of performance opportunities against benchmarks, utilizing risk adjustment software, and c) transparency through shared data on all claims relating to the identified population. These efforts occur prior to entering into a new payment arrangement, which enable the parties to collaborate on the terms of the payment model to fit the delivery system, when possible. Additionally, we use our predictive modeling tools to identify opportunities for clinical intervention and seek to develop a collaborative plan as part of the contracting process.

9) **Please explain and submit supporting documents that show whether and how you inform your members, or require providers to inform your members, when you reimburse providers for the services that they render to your members through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/ or deficit charged to a provider (regardless of whether those providers are "at risk" or are "upside only").**

Brief Summary: We do not currently provide or require providers to provide such information.

Response: We do not currently provide any specific information relative to our provider payment models to our members and do not require our providers to do so.

10) **Please explain and submit supporting documents that show how you identify, audit, and/ or prevent provider underutilization of needed services or avoidance of sicker patients where you reimburse those providers through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/ or deficit charged to a provider (regardless of whether those providers are "at risk" or are "upside only").**

Brief Summary: In our current risk-sharing arrangement we utilize “score cards” to set a range of utilization targets.

Response: In our current risk-sharing arrangement we utilize “score cards” to set targets for reduced utilization around inpatient readmissions, emergency department use, and other medical services, based upon historical experience and best practice benchmarks. We also set targets for referrals outside of the system.

The scorecards are reviewed on a quarterly basis by teams of staff within Network Health and the provider system. We also review these measures together with the provider clinical and business leadership on a regular basis. Furthermore, there specific staff whose function it is to review and identify opportunities for performance improvement, based upon regular review of pertinent data and benchmarks. To date, we have not identified any instances of underutilization. In addition, due to employment of risk-adjustment methodology, there is less incentive for avoidance of sicker patients.

Appendix A

Appendix A.1: *Relative Price - OP Hospital 2009*

OrgID	PROV_FULL_NAME	ins_code	multiplier	total payments
1	Anna Jaques Hospital	2	1.515	$462,049
1	Anna Jaques Hospital	3	1.116	$305,538
100	Mt. Auburn Hospital	2	1.53	$525,321
100	Mt. Auburn Hospital	3	1.397	$1,189,977
101	Nantucket Cottage Hospital	2	3.14	$3,674
101	Nantucket Cottage Hospital	3	2.654	$263,048
103	New England Baptist Hospital	2	0.98	$2,853
103	New England Baptist Hospital	3	0.94	$4,362
104	Tufts Medical Center Inc	2	1.437	$1,644,436
104	Tufts Medical Center Inc	3	1.576	$1,144,340
105	Newton-Wellesley Hospital	2	2.705	$535,262
105	Newton-Wellesley Hospital	3	1.986	$751,093
106	Noble Hospital	2	1.565	$89,561
106	Noble Hospital	3	1.584	$206,562
107	North Adams Regional Hospital	2	5.287	$2,438
107	North Adams Regional Hospital	3	0.958	$3,304
112	Quincy Medical Center	2	1.094	$64,761
112	Quincy Medical Center	3	1.288	$175,508
114	St Annes Hospital	2	1.967	$47,901
114	St Annes Hospital	3	2.05	$556,563
115	Saints Memorial Medical Center	2	2.144	$2,974,702
115	Saints Memorial Medical Center	3	1.517	$1,133,746
122	South Shore Hospital	2	2.23	$226,786
122	South Shore Hospital	3	1.34	$384,318
126	St Elizabeth's Medical Center	2	1.907	$201,830
126	St Elizabeth's Medical Center	3	2.338	$514,196
127	Saint Vincent Hospital	2	1.28	$1,790,713
127	Saint Vincent Hospital	3	1.326	$747,885
129	Sturdy Memorial Hospital Inc	2	0.982	$13,521
129	Sturdy Memorial Hospital Inc	3	0.975	$16,955
132	Clinton Hospital	2	5.819	$1,096,420
132	Clinton Hospital	3	5.005	$529,642
133	Marlborough Hospital	2	4.247	$1,061,802
133	Marlborough Hospital	3	3.348	$757,033
138	Winchester Hospital	2	1.361	$1,020,460
138	Winchester Hospital	3	1.122	$526,383
139	Wing Memorial Hospital	2	3.314	$1,091,943
139	Wing Memorial Hospital	3	3.37	$1,075,616
2	Athol Memorial Hospital	2	1.523	$482,647
2	Athol Memorial Hospital	3	1.358	$206,488

22	Brigham And Womens Hospital	2	2.489	$2,788,229
22	Brigham And Womens Hospital	3	2.091	$5,443,600
25	Brockton Hospital	2	1.418	$531,038
25	Brockton Hospital	3	1.598	$804,313
3107	Boston Medical Center	2	0.976	$352,419
3107	Boston Medical Center	3	0.987	$267,348
3108	The Cambridge Hospital	2	2.379	$14,515,058
3108	The Cambridge Hospital	3	2.245	$8,025,471
3110	Metrowest Medical Center	2	2.155	$1,522,858
3110	Metrowest Medical Center	3	1.968	$1,661,194
3111	Hallmark Health System Inc	2	2.542	$3,553,104
3111	Hallmark Health System Inc	3	1.961	$2,284,430
3112	Northeast Hospital Corp	2	1.988	$2,087,886
3112	Northeast Hospital Corp	3	1.663	$1,450,383
3113	South Coast Hospital Group Inc	2	1.06	$41,232
3113	South Coast Hospital Group Inc	3	1.015	$163,637
3115	Umass Memorial Medical Center	2	1.889	$17,935,685
3115	Umass Memorial Medical Center	3	1.729	$5,928,641
345	North Shore Medical Center	2	2.754	$3,182,327
345	North Shore Medical Center	3	1.937	$2,776,740
39	Cape Cod Hospital	2	2.973	$17,632
39	Cape Cod Hospital	3	1.105	$188,050
4	Baystate Medical Center Inc	2	1.246	$659,387
4	Baystate Medical Center Inc	3	0.936	$291,945
40	Falmouth Hospital	2	2.146	$7,347
40	Falmouth Hospital	3	1.447	$97,778
41	Caritas Norwood Hospital	2	1.143	$80,278
41	Caritas Norwood Hospital	3	1.175	$201,655
42	Carney Hospital	2	1.849	$192,420
42	Carney Hospital	3	1.976	$367,513
46	Childrens Hospital	2	3.205	$7,241,647
46	Childrens Hospital	3	3.241	$275,015
5	Baystate Franklin Medical Ctr	2	1.886	$36,514
5	Baystate Franklin Medical Ctr	3	1.748	$8,171
50	Cooley Dickinson Hospital	2	0.99	$21,647
50	Cooley Dickinson Hospital	3	0.966	$17,818
51	Dana Farber Cancer Institute	2	2.304	$1,737,157
51	Dana Farber Cancer Institute	3	1.975	$4,158,423
52	Nashoba Valley Medical Center	2	1.231	$471,864
52	Nashoba Valley Medical Center	3	1.241	$443,456
53	Beth Israel Deaconess Hospital	2	1.194	$47,873
53	Beth Israel Deaconess Hospital	3	1.046	$152,275
57	Emerson Hospital	2	1.154	$153,404
57	Emerson Hospital	3	1.055	$182,337
59	Faulkner Hospital	2	2.223	$361,119

59	Faulkner Hospital	3	1.655	$856,889
6	Mary Lane Hospital	2	1.823	$86,343
6	Mary Lane Hospital	3	1.256	$34,399
6309	Berkshire Medical Center	2	0.927	$11,985
6309	Berkshire Medical Center	3	0.985	$1,861
6546	Lahey Clinic Hospital	2	0.902	$125,415
6546	Lahey Clinic Hospital	3	0.952	$89,327
6547	Mercy Hospital Inc	2	1.558	$637,145
6547	Mercy Hospital Inc	3	1.415	$513,181
68	Harrington Memorial Hospital	2	1.483	$4,109,482
68	Harrington Memorial Hospital	3	1.563	$1,089,391
70	Merrimack Valley Hospital	2	1.229	$613,117
70	Merrimack Valley Hospital	3	1.014	$213,716
71	Health Alliance Hospital Inc.	2	2.929	$7,460,938
71	Health Alliance Hospital Inc.	3	2.793	$2,967,285
73	Henry Heywood Memorial Hosp	2	1.675	$2,160,943
73	Henry Heywood Memorial Hosp	3	1.249	$828,728
75	Holy Family Hospital	2	1.844	$2,038,552
75	Holy Family Hospital	3	1.849	$660,144
77	Holyoke Hospital (Medical)	2	1.747	$1,137,214
77	Holyoke Hospital (Medical)	3	1.74	$687,793
79	Jordan Hosp-Outpatient Dept	2	1.481	$47,734
79	Jordan Hosp-Outpatient Dept	3	1.339	$186,985
8	Fairview Hospital	3	0.96	$221
83	Lawrence General Hospital	2	1.721	$3,494,488
83	Lawrence General Hospital	3	1.647	$1,074,034
85	Lowell General Hospital	2	1.683	$3,680,158
85	Lowell General Hospital	3	1.586	$1,490,278
8701	Good Samaritan Medical	2	1.224	$254,751
8701	Good Samaritan Medical	3	1.138	$360,242
8702	Beth Israel Deaconess Med Ctr	2	1.735	$2,504,279
8702	Beth Israel Deaconess Med Ctr	3	1.473	$4,758,574
88	Martha's Vineyard Hospital	2	2.714	$6,056
88	Martha's Vineyard Hospital	3	1.998	$862,688
89	Mass Eye & Ear Infirmary	2	1.416	$1,441,445
89	Mass Eye & Ear Infirmary	3	1.327	$766,012
91	Massachusetts General Hospital	2	2.274	$10,725,879
91	Massachusetts General Hospital	3	2.211	$8,848,376
97	Milford Regional Med Ctr Inc	2	1.558	$780,781
97	Milford Regional Med Ctr Inc	3	1.456	$933,698
98	Milton Hospital Inc	2	3.741	$135,738
98	Milton Hospital Inc	3	2.817	$382,026
99	Morton Hospital	2	0.924	$12,316
99	Morton Hospital	3	0.932	$60,918

Appendix A.2: *Relative Price - OP Hospital 2010*

OrgID	PROV_FULL_NAME	ins_code	multiplier	total payments
1	Anna Jaques Hospital	2	1.471	$454,210
1	Anna Jaques Hospital	3	1.257	$308,727
100	Mt. Auburn Hospital	2	1.083	$592,827
100	Mt. Auburn Hospital	3	1.257	$880,309
101	Nantucket Cottage Hospital	2	3.412	$8,688
101	Nantucket Cottage Hospital	3	2.659	$352,019
103	New England Baptist Hospital	2	0.939	$4,892
103	New England Baptist Hospital	3	0.95	$2,332
104	Tufts Medical Center Inc	2	1.625	$2,653,182
104	Tufts Medical Center Inc	3	1.605	$1,318,553
105	Newton-Wellesley Hospital	2	2.492	$869,842
105	Newton-Wellesley Hospital	3	2.061	$873,011
106	Noble Hospital	2	0.997	$147,770
106	Noble Hospital	3	1.594	$179,500
107	North Adams Regional Hospital	2	1.848	$2,859
107	North Adams Regional Hospital	3	3.597	$993
112	Quincy Medical Center	2	1.18	$158,141
112	Quincy Medical Center	3	1.168	$179,644
114	St Annes Hospital	2	2.207	$266,196
114	St Annes Hospital	3	2.386	$709,125
115	Saints Memorial Medical Center	2	1.609	$2,101,392
115	Saints Memorial Medical Center	3	1.304	$834,938
122	South Shore Hospital	2	1.557	$559,878
122	South Shore Hospital	3	1.3	$404,943
126	St Elizabeth's Medical Center	2	2.168	$597,794
126	St Elizabeth's Medical Center	3	1.923	$463,931
127	Saint Vincent Hospital	2	1.326	$1,838,714
127	Saint Vincent Hospital	3	1.218	$697,134
129	Sturdy Memorial Hospital Inc	2	0.965	$42,402
129	Sturdy Memorial Hospital Inc	3	0.964	$19,333
132	Clinton Hospital	2	5.728	$1,204,230
132	Clinton Hospital	3	5.251	$643,426
133	Marlborough Hospital	2	4.162	$1,176,825
133	Marlborough Hospital	3	3.367	$782,908
138	Winchester Hospital	2	1.569	$1,177,242
138	Winchester Hospital	3	1.211	$637,433
139	Wing Memorial Hospital	2	3.021	$1,074,078
139	Wing Memorial Hospital	3	3.09	$1,077,589
2	Athol Memorial Hospital	2	1.325	$377,733
2	Athol Memorial Hospital	3	1.167	$219,192
22	Brigham And Womens Hospital	2	2.556	$3,983,411
22	Brigham And Womens Hospital	3	2.361	$4,460,854

25	Brockton Hospital	2	1.543	$1,283,412
25	Brockton Hospital	3	1.517	$911,381
3107	Boston Medical Center	2	0.954	$439,467
3107	Boston Medical Center	3	0.955	$157,880
3108	The Cambridge Hospital	2	2.394	$14,202,017
3108	The Cambridge Hospital	3	2.383	$6,189,704
3110	Metrowest Medical Center	2	2.193	$1,828,505
3110	Metrowest Medical Center	3	2.048	$1,705,955
3111	Hallmark Health System Inc	2	2.351	$3,526,303
3111	Hallmark Health System Inc	3	2.04	$2,069,160
3112	Northeast Hospital Corp	2	1.847	$1,762,887
3112	Northeast Hospital Corp	3	1.601	$1,332,411
3113	South Coast Hospital Group Inc	2	1.005	$178,629
3113	South Coast Hospital Group Inc	3	0.98	$203,808
3115	Umass Memorial Medical Center	2	1.858	$17,052,473
3115	UMASS Memorial Medical Center	3	1.507	$5,367,326
345	North Shore Medical Center	2	2.746	$4,253,524
345	North Shore Medical Center	3	1.876	$2,051,073
39	Cape Cod Hospital	2	1.611	$154,325
39	Cape Cod Hospital	3	1.393	$410,243
4	Baystate Medical Center Inc	2	1.017	$626,994
4	Baystate Medical Center Inc	3	0.819	$336,338
40	Falmouth Hospital	2	1.919	$78,841
40	Falmouth Hospital	3	1.838	$235,775
41	Caritas Norwood Hospital	2	1.343	$170,836
41	Caritas Norwood Hospital	3	1.296	$180,513
42	Carney Hospital	2	1.693	$442,987
42	Carney Hospital	3	2.07	$484,012
46	Childrens Hospital	2	3.042	$6,377,492
46	Childrens Hospital	3	3.173	$286,900
5	Baystate Franklin Medical Ctr	2	1.499	$1,868
5	Baystate Franklin Medical Ctr	3	0.92	$3,393
50	Cooley Dickinson Hospital	2	0.971	$23,915
50	Cooley Dickinson Hospital	3	0.87	$25,753
51	Dana Farber Cancer Institute	2	2.415	$2,085,796
51	Dana Farber Cancer Institute	3	2.123	$2,867,319
52	Nashoba Valley Medical Center	2	1.245	$474,920
52	Nashoba Valley Medical Center	3	1.202	$404,317
53	Beth Israel Deaconess Hospital	2	1.057	$60,039
53	Beth Israel Deaconess Hospital	3	1.064	$157,435
57	Emerson Hospital	2	1.158	$183,481
57	Emerson Hospital	3	1.006	$207,618
59	Faulkner Hospital	2	2.07	$603,994
59	Faulkner Hospital	3	1.612	$829,833
6	Mary Lane Hospital	2	1.77	$62,788

6	Mary Lane Hospital	3	1.18	$27,692
6309	Berkshire Medical Center	2	1.001	$4,697
6309	Berkshire Medical Center	3	0.948	$2,009
6546	Lahey Clinic Hospital	2	0.986	$219,158
6546	Lahey Clinic Hospital	3	1.003	$63,657
6547	Mercy Hospital Inc	2	1.259	$564,328
6547	Mercy Hospital Inc	3	1.304	$579,162
68	Harrington Memorial Hospital	2	1.603	$4,368,028
68	Harrington Memorial Hospital	3	1.718	$1,175,788
70	Merrimack Valley Hospital	2	0.987	$568,160
70	Merrimack Valley Hospital	3	1.166	$177,256
71	Health Alliance Hospital Inc.	2	2.808	$7,427,644
71	Health Alliance Hospital Inc.	3	2.769	$2,924,840
73	Henry Heywood Memorial Hosp	2	1.821	$2,311,963
73	Henry Heywood Memorial Hosp	3	1.447	$927,205
75	Holy Family Hospital	2	1.894	$1,934,558
75	Holy Family Hospital	3	1.807	$589,397
77	Holyoke Hospital (Medical)	2	1.72	$1,024,809
77	Holyoke Hospital (Medical)	3	1.745	$713,538
79	Jordan Hosp-Outpatient Dept	2	1.338	$127,589
79	Jordan Hosp-Outpatient Dept	3	1.189	$262,414
8	Fairview Hospital	2	1	$1,027
8	Fairview Hospital	3	1	$410
83	Lawrence General Hospital	2	1.679	$3,020,097
83	Lawrence General Hospital	3	1.584	$762,831
85	Lowell General Hospital	2	1.65	$4,221,451
85	Lowell General Hospital	3	1.783	$1,245,724
8701	Good Samaritan Medical	2	1.303	$490,087
8701	Good Samaritan Medical	3	1.261	$426,290
8702	Beth Israel Deaconess Med Ctr	2	2.438	$4,100,640
8702	Beth Israel Deaconess Med Ctr	3	2.081	$5,026,838
88	Martha's Vineyard Hospital	2	1.739	$52,099
88	Martha's Vineyard Hospital	3	1.863	$1,623,993
89	Mass Eye & Ear Infirmary	2	1.375	$1,547,090
89	Mass Eye & Ear Infirmary	3	1.368	$766,577
91	Massachusetts General Hospital	2	2.21	$11,904,304
91	Massachusetts General Hospital	3	2.135	$7,570,707
97	Milford Regional Medical Ctr	2	1.73	$931,749
97	Milford Regional Medical Ctr	3	1.557	$1,064,025
98	Milton Hospital Inc	2	3.581	$265,928
98	Milton Hospital Inc	3	3.045	$375,907
99	Morton Hospital	2	1.13	$61,139
99	Morton Hospital	3	1.061	$104,614

Appendix A.3: ***Relative Price – PhysGroup 2009***

Provider Org ID	Name	Provider Local Practice Group ID	LPG Name	Pediatric Indicator	Insurance Category Code	Multiplier	Total Payments
6755	UMass Memorial Health Care	9784	UMass Memorial Medical Group	0	2	1.317	$8,798,228
6755	UMass Memorial Health Care	9784	UMass Memorial Medical Group	0	3	1.226	$2,725,464
6755	UMass Memorial Health Care	999998	Other	0	2	1.109	$587,446
6755	UMass Memorial Health Care	999998	Other	0	3	1.055	$386,332
8745	Partners Community Health Care (PCHI)	8747	Cambridge Health Alliance Physicians Organization	0	2	1.328	$4,542,142
8745	Partners Community Health Care (PCHI)	8747	Cambridge Health Alliance Physicians Organization	0	3	1.353	$2,030,849
8745	Partners Community Health Care (PCHI)	9324	Massachusetts General Hospital Physicians Organization	0	2	1.868	$6,915,266
8745	Partners Community Health Care (PCHI)	9324	Massachusetts General Hospital Physicians Organization	0	3	1.965	$5,234,672
8745	Partners Community Health Care (PCHI)	10996	Brigham And Women's Physicians Organization	0	2	1.648	$1,822,883
8745	Partners Community Health Care (PCHI)	10996	Brigham And Women's Physicians Organization	0	3	1.849	$3,068,251
8745	Partners Community Health Care (PCHI)	999998	Other	0	2	1.303	$3,272,015
8745	Partners Community Health Care (PCHI)	999998	Other	0	3	1.331	$2,461,058
10326	HealthAlliance With Physicians	10975	CentMass Association of Physicians	0	2	1.224	$4,788,425
10326	HealthAlliance With Physicians	10975	CentMass Association of Physicians	0	3	1.150	$1,107,860
10968	Beth Israel Deaconess PHO	999998	Other	0	2	1.119	$2,771,579
10968	Beth Israel Deaconess PHO	999998	Other	0	3	1.100	$2,899,264
10977	Choice Plus Network/Lawrence General IPA	10977	Choice Plus Network/Lawrence General IPA	0	2	1.199	$3,533,762
10977	Choice Plus Network/Lawrence General IPA	10977	Choice Plus Network/Lawrence General IPA	0	3	1.179	$955,631
10978	Lowell General PHO	10978	Lowell General PHO	0	2	1.206	$4,151,570
10978	Lowell General PHO	10978	Lowell General PHO	0	3	1.107	$893,255
11018	The Childrens Hospital Corporation	9923	Pediatric Physician's Organization at Children's (PPOC)	1	2	4.665	$8,086,102
11018	The Childrens Hospital Corporation	9923	Pediatric Physician's Organization at Children's (PPOC)	1	3	4.431	$238,331
999998	Other	999998	Other	0	2	1.254	$46,255,238
999998	Other	999998	Other	0	3	1.109	$19,259,569

Attachment A.4: Total Medical Expense PMPM 2009

Physician Group	Local_Practice_Group_Org_ID	PMPM	HA PMPM	NHA PMPM	Negotiated PMPM
Beth Israel Deaconess	999997	$443	$534	$422	No
Cambridge Health Alliance	999997	$380	$514	$405	No
Cambridge Health Alliance	V38975	$374	$480	$378	No
Cambridge Health Alliance	V40919	$351	$475	$374	No
Melrose-Wakefield IPA	999997	$422	$502	$398	No
Massachusetts General PHO	999997	$448	$554	$435	No
Massachusetts General PHO	V49078	$456	$530	$418	No
UMass Medical System	999997	$407	$447	$354	No
UMass Medical System	V45052	$441	$490	$387	No
Heywood Memorial Hospital	999997	$328	$377	$298	No
Harrington Memorial Hospital	999997	$391	$387	$306	No
Lowell General Hospital PHO	999997	$331	$404	$316	No
Choice Plus Network/Lawrence General IPA	999997	$271	$387	$304	No
Lowell Community Health Center	V46363	$367	$483	$378	No
Pentucket Medical Associates	V44446	$403	$452	$356	No
Greater Lawrence Family Hlth Ctr	999997	$239	$461	$363	No
Greater Lawrence Family Hlth Ctr	V49222	$379	$505	$395	No
CCA/BIDMC CHC	999997	$320	$562	$439	No
CCA/BIDMC CHC	V49474	$214	$475	$375	No
Central Mass IPA	999997	$291	$388	$307	No
CentMA IPA	999997	$317	$407	$317	No
Children's Hosp PPOC	999997	$219	$365	$285	No

Attachment A.5: Total Medical Expense PMPM 2010

Physician group	Local_Practice_Group_Org_ID	pmpm	HA pmpm	NHA pmpm	Negotiated PMPM
Beth Israel Deaconess	999997	$594	$582	$476	No
Cambridge Health Alliance	V38975	$430	$476	$389	No
Cambridge Health Alliance	999997	$499	$516	$422	No
Melrose-Wakefield IPA	999997	$526	$520	$425	No
Massachusetts General PHO	V49078	$560	$555	$453	No
Massachusetts General PHO	999997	$480	$516	$421	No
UMass Medical System	V45052	$470	$455	$372	No
UMass Medical System	999997	$461	$528	$432	No
Heywood Memorial Hospital	999997	$381	$384	$313	No
Harrington Memorial Hospital	999997	$428	$394	$322	No
Lowell General Hospital PHO	999997	$371	$408	$333	No
Pentucket Medical Associates	V44446	$378	$406	$332	No
CCA/BIDMC CHC	999997	$415	$557	$455	No
Central Mass IPA	999997	$286	$344	$281	No
CentMA IPA	999997	$356	$411	$336	No
Children's Hosp PPOC	999997	$290	$405	$331	No

APPENDIX B

Network Health Cost & Utilization by Business & Major Type of Service: CY 2005 - CY 2010

I. Commonwealth Care -- Forward

	Total PMPM Growth[1]									% of Total PMPM Growth[2]									% Change in PMPM									% Attributed to CPU and Utilization											
																												2006 : 2007		2007 : 2008		2008 : 2009		2009 : 2010		2006 : 2008		2006 : 2009		2006 : 2010		2005 : 2010	
Service	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization
Inpatient Hospital[3]	N/A	$6.69	$2.50	$9.95	$0.91	$9.20	$19.15	$20.06	N/A	N/A	8.8%	15.0%	16.8%	14.6%	9.9%	12.6%	12.6%	N/A	N/A	11.1%	3.7%	14.3%	1.1%	15.3%	31.7%	33.3%	N/A	44.2%	-23.0%	11.7%	-7.1%	-4.6%	19.8%	-2.3%	3.5%	61.1%	-28.4%	53.7%	-14.3%	50.2%	-11.3%	N/A	N/A
Outpatient Hospital[4]	N/A	$25.53	($6.39)	$16.53	($0.78)	$19.14	$35.67	$34.89	N/A	N/A	33.4%	-38.2%	27.9%	-12.4%	20.6%	23.4%	22.0%	N/A	N/A	29.5%	-5.7%	15.7%	-0.6%	22.1%	41.3%	40.4%	N/A	10.4%	17.3%	-9.0%	3.6%	3.3%	12.0%	-3.1%	2.5%	0.5%	21.5%	3.8%	36.1%	0.6%	39.5%	N/A	N/A
Professional/Physician[5]	N/A	$23.82	$7.75	$16.48	$5.49	$31.57	$48.05	$53.54	N/A	N/A	31.2%	46.4%	27.8%	88.0%	33.9%	31.5%	33.8%	N/A	N/A	49.0%	10.7%	20.6%	5.7%	65.0%	98.9%	110.2%	N/A	-1.9%	51.9%	1.4%	9.2%	-12.3%	37.5%	1.2%	4.4%	-0.5%	65.8%	-12.8%	128.0%	-11.7%	138.1%	N/A	N/A
Pharmacy[6]	N/A	$17.29	$9.25	$13.52	$4.40	$26.53	$40.05	$44.45	N/A	N/A	22.6%	55.3%	22.8%	70.5%	28.5%	26.3%	28.0%	N/A	N/A	79.0%	23.6%	27.9%	7.1%	121.2%	182.9%	203.0%	N/A	16.0%	54.2%	3.1%	19.9%	3.5%	23.6%	-0.7%	7.8%	19.6%	85.0%	23.7%	128.7%	22.9%	146.5%	N/A	N/A
All Other Claims[7]	N/A	$3.04	$3.60	$2.79	($3.78)	$6.64	$9.44	$5.65	N/A	N/A	4.0%	21.5%	4.7%	-60.6%	7.1%	6.2%	3.6%	N/A	N/A	492.9%	98.4%	38.5%	-37.6%	1076.5%	1529.3%	916.3%	N/A	362.5%	28.2%	13.5%	74.8%	-4.8%	45.4%	-17.1%	-24.7%	45.6%	708.3%	38.6%	1075.2%	14.9%	784.7%	N/A	N/A
Total:	**N/A**	**$76.37**	**$16.71**	**$59.28**	**$6.24**	**$93.08**	**$152.35**	**$158.60**	**N/A**	**N/A**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**N/A**	**N/A**	**35.1%**	**5.7%**	**19.1%**	**1.7%**	**42.7%**	**69.9%**	**72.8%**	**N/A**	**-9.5%**	**49.2%**	**-6.5%**	**13.0%**	**-9.0%**	**30.8%**	**-2.5%**	**4.2%**	**-15.3%**	**68.6%**	**-22.9%**	**120.5%**	**-24.8%**	**129.9%**	**N/A**	**N/A**

II. Mass Health -- Together

	Total PMPM Growth[1]									% of Total PMPM Growth[2]									% Change in PMPM									% Attributed to CPU and Utilization											
																												2006 : 2007		2007 : 2008		2008 : 2009		2009 : 2010		2006 : 2008		2006 : 2009		2006 : 2010		2005 : 2010	
Service	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization
Inpatient Hospital[3]	$9.96	$15.15	$16.48	($7.75)	$0.15	$31.62	$23.87	$24.02	$33.98	35.8%	40.8%	81.4%	-89.4%	-17.3%	55.1%	36.1%	36.8%	36.5%	14.1%	18.8%	17.2%	-6.9%	0.1%	39.3%	29.7%	29.8%	48.2%	17.6%	1.0%	15.1%	1.8%	-9.6%	3.0%	-7.4%	8.2%	35.4%	2.9%	22.4%	5.9%	13.3%	14.6%	13.1%	31.0%
Outpatient Hospital[4]	$10.73	$9.70	($6.03)	$5.10	($2.54)	$3.67	$8.77	$6.24	$16.96	38.6%	26.1%	-29.8%	58.8%	290.0%	6.4%	13.3%	9.6%	18.2%	14.8%	11.6%	-6.5%	5.9%	-2.8%	4.4%	10.5%	7.5%	23.3%	9.5%	1.9%	-9.9%	3.7%	1.3%	4.5%	-2.6%	-0.2%	-1.3%	5.8%	0.0%	10.5%	-2.5%	10.3%	12.4%	9.7%
Professional/Physician[5]	$6.07	$8.44	$6.40	$10.03	$3.04	$14.84	$24.87	$27.91	$33.98	21.8%	22.7%	31.6%	115.6%	-348.3%	25.9%	37.6%	42.8%	36.5%	7.6%	9.8%	6.8%	9.9%	2.7%	17.2%	28.9%	32.4%	42.5%	6.9%	2.7%	-1.2%	8.0%	-6.4%	17.5%	-4.4%	7.5%	5.7%	10.9%	-1.1%	30.3%	-5.5%	40.1%	42.8%	-0.2%
Pharmacy[6]	$1.05	$3.86	$3.41	$1.29	($1.53)	$7.26	$8.55	$7.02	$8.07	3.8%	10.4%	16.8%	14.9%	175.2%	12.7%	12.9%	10.8%	8.7%	2.6%	9.2%	7.5%	2.6%	-3.0%	17.4%	20.4%	16.8%	19.8%	9.3%	0.0%	3.4%	3.9%	-3.8%	6.7%	-2.9%	-0.1%	13.0%	3.9%	8.7%	10.8%	5.5%	10.6%	12.6%	6.4%
All Other Claims[7]	$0.00	$0.00	$0.00	$0.00	($0.00)	$0.00	$0.00	$0.00	$0.00	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	N/A	N/A	385.8%	30.1%	-72.4%	N/A	N/A	N/A	N/A	N/A	N/A	-7.3%	424.0%	5.7%	23.1%	-21.9%	-64.7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total:	**$27.80**	**$37.15**	**$20.25**	**$8.67**	**($0.87)**	**$57.39**	**$66.07**	**$65.19**	**$92.99**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.5%**	**12.7%**	**6.2%**	**2.5%**	**-0.2%**	**19.7%**	**22.6%**	**22.3%**	**33.1%**	**10.5%**	**2.0%**	**-0.5%**	**6.7%**	**-10.1%**	**14.0%**	**-5.3%**	**5.3%**	**10.0%**	**8.8%**	**-1.1%**	**24.0%**	**-6.3%**	**30.6%**	**1.6%**	**33.1%**

III. Consolidated

	Total PMPM Growth[1]									% of Total PMPM Growth[2]									% Change in PMPM									% Attributed to CPU and Utilization											
																												2006 : 2007		2007 : 2008		2008 : 2009		2009 : 2010		2006 : 2008		2006 : 2009		2006 : 2010		2005 : 2010	
Service	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	2005 : 2006	2006 : 2007	2007 : 2008	2008 : 2009	2009 : 2010	2006 : 2008	2006 : 2009	2006 : 2010	2005 : 2010	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization	CPU	Utilization
Inpatient Hospital[3]	$9.76	$6.89	$8.07	$0.92	$1.29	$14.96	$15.88	$17.17	$26.93	36.0%	24.9%	52.5%	3.3%	172.6%	34.8%	22.4%	24.0%	27.3%	13.8%	8.6%	9.3%	1.0%	1.3%	18.6%	19.8%	21.4%	38.2%	9.2%	-0.6%	11.6%	-2.1%	-7.3%	9.0%	-5.1%	6.7%	21.8%	-2.6%	12.9%	6.1%	7.2%	13.3%	12.1%	23.3%
Outpatient Hospital[4]	$10.76	$15.24	($4.28)	$7.62	($3.13)	$10.97	$18.59	$15.46	$26.22	39.7%	55.2%	-27.8%	27.3%	-417.9%	25.5%	26.2%	21.6%	26.6%	14.8%	18.3%	-4.3%	8.1%	-3.1%	13.1%	22.3%	18.5%	36.1%	12.3%	5.3%	-8.7%	4.8%	1.6%	6.4%	-3.1%	0.0%	2.5%	10.3%	4.2%	17.4%	0.9%	17.4%	19.7%	13.7%
Professional/Physician[5]	$5.70	$2.29	$4.71	$13.54	$4.28	$7.00	$20.54	$24.83	$30.53	21.1%	8.3%	30.7%	48.6%	573.0%	16.3%	29.0%	34.7%	30.9%	7.1%	2.7%	5.4%	14.6%	4.0%	8.2%	24.0%	29.0%	38.2%	8.7%	-5.5%	0.4%	5.0%	-8.5%	25.3%	-3.1%	7.4%	9.1%	-0.8%	-0.2%	24.3%	-3.3%	33.4%	35.2%	2.2%
Pharmacy[6]	$0.85	$2.13	$5.06	$5.36	($0.23)	$7.19	$12.55	$12.32	$13.17	3.1%	7.7%	32.9%	19.2%	-30.1%	16.7%	17.7%	17.2%	13.3%	2.1%	5.1%	11.6%	11.0%	-0.4%	17.3%	30.1%	29.6%	32.3%	2.4%	2.7%	0.1%	11.4%	-0.4%	11.4%	-1.7%	1.4%	2.5%	14.4%	2.1%	27.4%	0.3%	29.2%	31.1%	0.9%
All Other Claims[7]	$0.01	$1.08	$1.79	$0.43	($1.46)	$2.87	$3.30	$1.83	$1.83	0.0%	3.9%	11.7%	1.6%	-197.6%	6.7%	4.7%	2.6%	1.9%	N/A	17713.3%	166.0%	15.1%	-44.6%	47287.5%	54433.5%	30090.1%	N/A	28.2%	13795.0%	13.5%	134.3%	-4.7%	20.8%	-17.1%	-33.2%	45.6%	32456.0%	38.7%	39231.2%	14.9%	26179.3%	N/A	N/A
Total:	**$27.07**	**$27.62**	**$15.36**	**$27.87**	**$0.75**	**$42.98**	**$70.86**	**$71.61**	**$98.68**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**10.3%**	**9.5%**	**4.8%**	**8.3%**	**0.2%**	**14.8%**	**24.3%**	**24.6%**	**37.4%**	**11.9%**	**-2.2%**	**-2.2%**	**7.2%**	**-9.7%**	**20.0%**	**-4.5%**	**4.9%**	**9.4%**	**4.9%**	**-1.2%**	**25.8%**	**-5.6%**	**32.0%**	**2.6%**	**33.9%**

NOTES:

1. *A negative variance indicates a decrease from one calendar year to the next, while a positive variance indicates an increase from one calendar year to the next.*
2. *Defined as the % each service contributes to the overall PMPM change from one year to the next year.*
3. *Defined as any claim tracking to service category code 100 (Facility Inpatient). Based off of discharge date.*
4. *Defined as any claim tracking to service category code 200 (Facility Outpatient) or service category code 400 (Ancillary) with a claim type of U (UB). Based off of date of service.*
5. *Defined as any claim tracking to service category code 300 (Professional Services) or service category code 400 (Ancillary) with a claim type of H (HCFA). Based off of date of service.*
6. *Defined as any claim tracking in the Rx Data Table in NWHCONN-BETA Datawarehouse.*
7. *Defined as any Dental or Vision claim.*

Network Health Cost &Utilization by Business & Major Type of Service: CY 2005 - CY 2010

I. Commonwealth Care -- Forward

	Calendar Year																													
	2005					2006					2007					2008					2009					2010				
Member Months:	0					9,373					432,591					748,475					619,561					579,229				
Major Type of Service	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]
Inpatient Hospital[7]	0	0	$0	$0	$0.00	154	711	$4,712	$1,019	$60.32	118	606	$6,796	$1,327	$67.02	110	580	$7,589	$1,439	$69.52	132	742	$7,243	$1,284	$79.47	136	781	$7,078	$1,234	$80.38
Outpatient Hospital[8]	0	0	$0	$0	$0.00	3,376	19,524	$307	$53	$86.43	3,961	25,912	$339	$52	$111.96	4,103	26,673	$309	$47	$105.57	4,596	28,192	$319	$52	$122.10	4,711	25,560	$309	$57	$121.32
Professional/Physician[9]	0	0	$0	$0	$0.00	6,077	13,595	$96	$43	$48.59	8,760	20,645	$99	$42	$72.41	9,648	22,547	$100	$43	$80.16	11,589	31,004	$100	$37	$96.65	12,290	32,372	$100	$38	$102.14
Pharmacy[10]		0		$0	$0.00		6,807		$39	$21.89		10,499		$45	$39.18		12,592		$46	$48.42		15,565		$48	$61.95		16,781		$47	$66.34
All Other Claims[11]	0	0	$0	$0	$0.00	96	155	$77	$48	$0.62	361	716	$122	$61	$3.66	627	1,252	$139	$70	$7.26	831	1,821	$145	$66	$10.05	652	1,370	$115	$55	$6.27
Total Utilization/1000:[12]					**0**					**24,087**					**35,940**					**40,604**					**53,117**					**55,371**
Total CPU:[13]					**$0**					**$109**					**$98**					**$92**					**$84**					**$82**
Total PMPM:					**$0.00**					**$217.86**					**$294.23**					**$310.94**					**$370.22**					**$376.46**

	% Change[6]																								
	2005 : 2006					2006 : 2007					2007 : 2008					2008 : 2009					2009 : 2010				
Member Months:	N/A					4515.3%					73.0%					-17.2%					-6.5%				
Major Type of Service	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM
Inpatient Hospital[7]	N/A	N/A	N/A	N/A	N/A	-23.0%	-14.7%	44.2%	30.3%	11.1%	-7.1%	-4.3%	11.7%	8.4%	3.7%	19.8%	28.0%	-4.6%	-10.7%	14.3%	3.5%	5.2%	-2.3%	-3.9%	1.1%
Outpatient Hospital[8]	N/A	N/A	N/A	N/A	N/A	17.3%	32.7%	10.4%	-2.4%	29.5%	3.6%	2.9%	-9.0%	-8.4%	-5.7%	12.0%	5.7%	3.3%	9.4%	15.7%	2.5%	-9.3%	-3.1%	9.6%	-0.6%
Professional/Physician[9]	N/A	N/A	N/A	N/A	N/A	44.1%	51.9%	3.4%	-1.9%	49.0%	10.1%	9.2%	0.5%	1.4%	10.7%	20.1%	37.5%	0.4%	-12.3%	20.6%	6.0%	4.4%	-0.3%	1.2%	5.7%
Pharmacy[10]		N/A		N/A	N/A		54.2%		16.0%	79.0%		19.9%		3.1%	23.6%		23.6%		3.5%	27.9%		7.8%		-0.7%	7.1%
All Other Claims[11]	N/A	N/A	N/A	N/A	N/A	276.0%	362.5%	57.7%	28.2%	492.9%	73.7%	74.8%	14.2%	13.5%	98.4%	32.4%	45.4%	4.6%	-4.8%	38.5%	-21.6%	-24.7%	-20.5%	-17.1%	-37.6%
Total Utilization/1000:[12]					**N/A**					**49.2%**					**13.0%**					**30.8%**					**4.2%**
Total CPU:[13]					**N/A**					**-9.5%**					**-6.5%**					**-9.0%**					**-2.5%**
Total PMPM:					**N/A**					**35.1%**					**5.7%**					**19.1%**					**1.7%**

	% Change[6]																			
	2006 : 2008					2006 : 2009					2006 : 2010					2005 : 2010				
Member Months:	7885.4%					6510.1%					6079.8%					0.0%				
Major Type of Service	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM
Inpatient Hospital[7]	-28.4%	-18.4%	61.1%	41.2%	15.3%	-14.3%	4.5%	53.7%	26.1%	31.7%	-11.3%	10.0%	50.2%	21.2%	33.3%	N/A	N/A	N/A	N/A	N/A
Outpatient Hospital[8]	21.5%	36.6%	0.5%	-10.6%	22.1%	36.1%	44.4%	3.8%	-2.2%	41.3%	39.5%	30.9%	0.6%	7.2%	40.4%	N/A	N/A	N/A	N/A	N/A
Professional/Physician[9]	58.8%	65.8%	3.9%	-0.5%	65.0%	90.7%	128.0%	4.3%	-12.8%	98.9%	102.2%	138.1%	3.9%	-11.7%	110.2%	N/A	N/A	N/A	N/A	N/A
Pharmacy[10]		85.0%		19.6%	121.2%		128.7%		23.7%	182.9%		146.5%		22.9%	203.0%		N/A		N/A	N/A
All Other Claims[11]	553.3%	708.3%	80.1%	45.6%	1076.5%	765.0%	1075.2%	88.4%	38.6%	1529.3%	578.6%	784.7%	49.8%	14.9%	916.3%	N/A	N/A	N/A	N/A	N/A
Total Utilization/1000:[12]					**68.6%**					**120.5%**					**129.9%**					**N/A**
Total CPU:[13]					**-15.3%**					**-22.9%**					**-24.8%**					**N/A**
Total PMPM:					**42.7%**					**69.9%**					**72.8%**					**N/A**

II. Mass Health -- Together

	Calendar Year																													
	2005					2006					2007					2008					2009					2010				
Member Months:	845,291					943,659					1,032,080					1,142,455					1,264,344					1,404,317				
Major Type of Service	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]
Inpatient Hospital[7]	124	674	$6,808	$1,256	$70.55	123	666	$7,872	$1,450	$80.50	124	700	$9,257	$1,640	$95.65	126	707	$10,656	$1,902	$112.12	130	725	$9,635	$1,727	$104.37	141	788	$8,920	$1,592	$104.53
Outpatient Hospital[8]	3,433	16,839	$254	$52	$72.66	3,499	16,998	$286	$59	$83.39	3,567	19,068	$313	$59	$93.09	3,701	18,846	$282	$55	$87.06	3,866	18,233	$286	$61	$92.16	3,859	18,785	$279	$57	$89.63
Professional/Physician[9]	10,745	27,676	$89	$35	$79.98	11,008	28,201	$94	$37	$86.05	11,191	28,962	$101	$39	$94.49	11,559	31,285	$105	$39	$100.89	12,534	36,758	$106	$36	$110.92	12,763	39,514	$107	$35	$113.96
Pharmacy[10]		9,544		$51	$40.80		9,714		$52	$41.84		9,710		$56	$45.70		10,092		$58	$49.11		10,763		$56	$50.40		10,747		$55	$48.87
All Other Claims[11]	0	0	$0	$0	$0.00	0	0	$0	$0	$0.00	0	0	$76	$76	$0.00	1	1	$70	$70	$0.00	1	1	$74	$74	$0.00	0	0	$58	$58	$0.00
Total Utilization/1000:[12]					**40,777**					**41,537**					**42,364**					**45,205**					**51,518**					**54,262**
Total CPU:[13]					**$78**					**$84**					**$93**					**$93**					**$83**					**$79**
Total PMPM:					**$263.99**					**$291.79**					**$328.93**					**$349.18**					**$357.85**					**$356.98**

	% Change[6]																								
	2005 : 2006					2006 : 2007					2007 : 2008					2008 : 2009					2009 : 2010				
Member Months:	11.6%					9.4%					10.7%					10.7%					11.1%				
Major Type of Service	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM
Inpatient Hospital[7]	-1.3%	-1.2%	15.6%	15.5%	14.1%	1.0%	5.1%	17.6%	13.1%	18.8%	1.8%	1.1%	15.1%	16.0%	17.2%	3.0%	2.5%	-9.6%	-9.2%	-6.9%	8.2%	8.6%	-7.4%	-7.8%	0.1%
Outpatient Hospital[8]	1.9%	0.9%	12.6%	13.7%	14.8%	1.9%	12.2%	9.5%	-0.5%	11.6%	3.7%	-1.2%	-9.9%	-5.4%	-6.5%	4.5%	-3.3%	1.3%	9.4%	5.9%	-0.2%	3.0%	-2.6%	-5.6%	-2.8%
Professional/Physician[9]	2.5%	1.9%	5.0%	5.6%	7.6%	1.7%	2.7%	8.0%	6.9%	9.8%	3.3%	8.0%	3.4%	-1.2%	6.8%	8.4%	17.5%	1.4%	-6.4%	9.9%	1.8%	7.5%	0.9%	-4.4%	2.7%
Pharmacy[10]		1.8%		0.8%	2.6%		0.0%		9.3%	9.2%		3.9%		3.4%	7.5%		6.7%		-3.8%	2.6%		-0.1%		-2.9%	-3.0%
All Other Claims[11]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	424.0%	424.0%	-7.3%	-7.3%	385.8%	23.1%	23.1%	5.7%	5.7%	30.1%	-64.7%	-64.7%	-21.9%	-21.9%	-72.4%
Total Utilization/1000:[12]					**1.9%**					**2.0%**					**6.7%**					**14.0%**					**5.3%**
Total CPU:[13]					**8.5%**					**10.5%**					**-0.5%**					**-10.1%**					**-5.3%**
Total PMPM:					**10.5%**					**12.7%**					**6.2%**					**2.5%**					**-0.2%**

	% Change[6]																			
	2006 : 2008					2006 : 2009					2006 : 2010					2005 : 2010				
Member Months:	21.1%					34.0%					48.8%					66.1%				
Major Type of Service	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM
Inpatient Hospital[7]	2.9%	6.2%	35.4%	31.2%	39.3%	5.9%	8.9%	22.4%	19.1%	29.7%	14.6%	18.3%	13.3%	9.8%	29.8%	13.1%	16.9%	31.0%	26.8%	48.2%
Outpatient Hospital[8]	5.8%	10.9%	-1.3%	-5.8%	4.4%	10.5%	7.3%	0.0%	3.0%	10.5%	10.3%	10.5%	-2.5%	-2.7%	7.5%	12.4%	11.6%	9.7%	10.6%	23.3%
Professional/Physician[9]	5.0%	10.9%	11.7%	5.7%	17.2%	13.9%	30.3%	13.2%	-1.1%	28.9%	15.9%	40.1%	14.2%	-5.5%	32.4%	18.8%	42.8%	20.0%	-0.2%	42.5%
Pharmacy[10]		3.9%		13.0%	17.4%		10.8%		8.7%	20.4%		10.6%		5.5%	16.8%		12.6%		6.4%	19.8%
All Other Claims[11]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Utilization/1000:[12]					**8.8%**					**24.0%**					**30.6%**					**33.1%**
Total CPU:[13]					**10.0%**					**-1.1%**					**-6.3%**					**1.6%**
Total PMPM:					**19.7%**					**22.6%**					**22.3%**					**35.2%**

III. Consolidated

	Calendar Year																													
	2005					2006					2007					2008					2009					2010				
Member Months:	845,291					953,032					1,464,671					1,890,930					1,883,905					1,983,546				
Major Type of Service	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]	Adm/ 1000[1]	Units/ 1000[2]	Cost/ Adm[3]	Cost/ Unit[4]	Cost PMPM[5]
Inpatient Hospital[7]	124	674	$6,808	$1,256	$70.55	123	667	$7,833	$1,446	$80.30	122	672	$8,554	$1,557	$87.19	120	657	$9,542	$1,740	$95.26	131	731	$8,841	$1,579	$96.18	139	786	$8,394	$1,488	$97.47
Outpatient Hospital[8]	3,433	16,839	$254	$52	$72.66	3,498	17,023	$286	$59	$83.42	3,683	21,090	$321	$56	$98.66	3,860	21,944	$293	$52	$94.39	4,106	21,508	$298	$57	$102.01	4,108	20,763	$289	$57	$98.88
Professional/Physician[9]	10,745	27,676	$89	$35	$79.98	10,960	28,057	$94	$37	$85.68	10,473	26,506	$101	$40	$87.97	10,803	27,826	$103	$40	$92.68	12,223	34,866	$104	$37	$106.22	12,625	37,429	$105	$35	$110.51
Pharmacy[10]		9,544		$51	$40.80		9,685		$52	$41.65		9,943		$53	$43.77		11,082		$53	$48.84		12,342		$53	$54.19		12,509		$52	$53.97
All Other Claims[11]	0	0	$0	$0	$0.00	1	2	$77	$48	$0.01	107	212	$122	$61	$1.08	249	496	$139	$70	$2.88	274	599	$145	$66	$3.31	190	400	$115	$55	$1.83
Total Utilization/1000:[12]					**40,777**					**41,365**					**40,467**					**43,384**					**52,044**					**54,586**
Total CPU:[13]					**$78**					**$84**					**$95**					**$92**					**$83**					**$80**
Total PMPM:					**$263.99**					**$291.06**					**$318.68**					**$334.04**					**$361.92**					**$362.67**

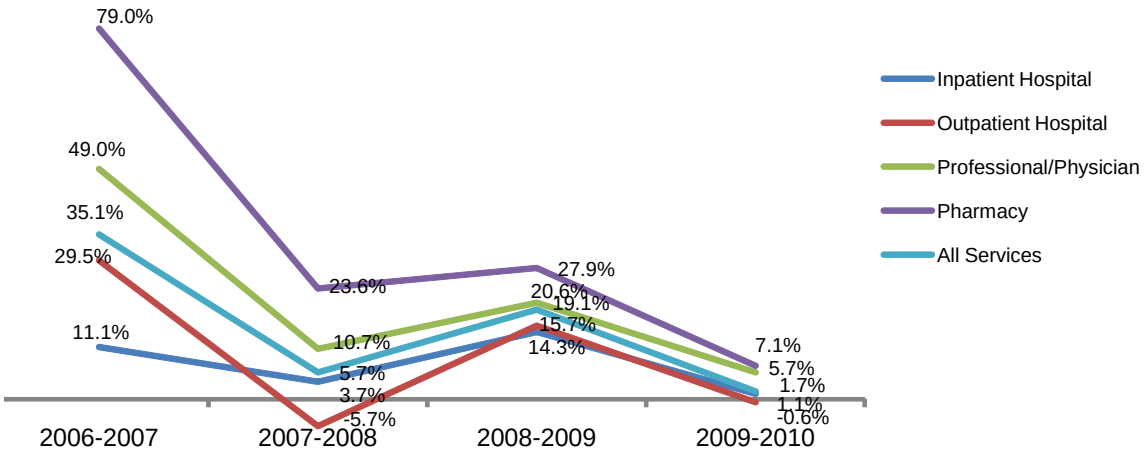
	% Change[6]																								
	2005 : 2006					2006 : 2007					2007 : 2008					2008 : 2009					2009 : 2010				
Member Months:	12.7%					53.7%					29.1%					-0.4%					5.3%				
Major Type of Service	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM
Inpatient Hospital[7]	-1.1%	-1.1%	15.1%	15.1%	13.8%	-0.6%	0.8%	9.2%	7.7%	8.6%	-2.1%	-2.3%	11.6%	11.8%	9.3%	9.0%	11.3%	-7.3%	-9.3%	1.0%	6.7%	7.5%	-5.1%	-5.8%	1.3%
Outpatient Hospital[8]	1.9%	1.1%	12.7%	13.6%	14.8%	5.3%	23.9%	12.3%	-4.5%	18.3%	4.8%	4.1%	-8.7%	-8.1%	-4.3%	6.4%	-2.0%	1.6%	10.3%	8.1%	0.0%	-3.5%	-3.1%	0.4%	-3.1%
Professional/Physician[9]	2.0%	1.4%	5.0%	5.7%	7.1%	-4.4%	-5.5%	7.4%	8.7%	2.7%	3.1%	5.0%	2.1%	0.4%	5.4%	13.1%	25.3%	1.3%	-8.5%	14.6%	3.3%	7.4%	0.7%	-3.1%	4.0%
Pharmacy[10]		1.5%		0.6%	2.1%		2.7%		2.4%	5.1%		11.4%		0.1%	11.6%		11.4%		-0.4%	11.0%		1.4%		-1.7%	-0.4%
All Other Claims[11]	N/A	N/A	N/A	N/A	N/A	11201.0%	13795.0%	57.6%	28.2%	17713.3%	133.0%	134.3%	14.2%	13.5%	166.0%	10.0%	20.8%	4.6%	-4.7%	15.1%	-30.4%	-33.2%	-20.5%	-17.1%	-44.6%
Total Utilization/1000:[12]					**1.4%**					**-2.2%**					**7.2%**					**20.0%**					**4.9%**
Total CPU:[13]					**8.7%**					**11.9%**					**-2.2%**					**-9.7%**					**-4.5%**
Total PMPM:					**10.3%**					**9.5%**					**4.8%**					**8.3%**					**0.2%**

	% Change[6]																			
	2006 : 2008					2006 : 2009					2006 : 2010					2005 : 2010				
Member Months:	98.4%					97.7%					108.1%					134.7%				
Major Type of Service	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM	Adm/ 1000	Units/ 1000	Cost/ Adm	Cost/ Unit	Cost PMPM
Inpatient Hospital[7]	-2.6%	-1.4%	21.8%	20.4%	18.6%	6.1%	9.7%	12.9%	9.2%	19.8%	13.3%	17.9%	7.2%	2.9%	21.4%	12.1%	16.6%	23.3%	18.5%	38.2%
Outpatient Hospital[8]	10.3%	28.9%	2.5%	-12.2%	13.1%	17.4%	26.4%	4.2%	-3.2%	22.3%	17.4%	22.0%	0.9%	-2.8%	18.5%	19.7%	23.3%	13.7%	10.4%	36.1%
Professional/Physician[9]	-1.4%	-0.8%	9.7%	9.1%	8.2%	11.5%	24.3%	11.2%	-0.2%	24.0%	15.2%	33.4%	12.0%	-3.3%	29.0%	17.5%	35.2%	17.6%	2.2%	38.2%
Pharmacy[10]		14.4%		2.5%	17.3%		27.4%		2.1%	30.1%		29.2%		0.3%	29.6%		31.1%		0.9%	32.3%
All Other Claims[11]	26233.1%	32456.0%	80.0%	45.6%	47287.5%	28878.9%	39231.2%	88.2%	38.7%	54433.5%	20068.8%	26179.3%	49.7%	14.9%	30090.1%	N/A	N/A	N/A	N/A	N/A
Total Utilization/1000:[12]					**4.9%**					**25.8%**					**32.0%**					**33.9%**
Total CPU:[13]					**9.4%**					**-1.2%**					**-5.6%**					**2.6%**
Total PMPM:					**14.8%**					**24.3%**					**24.6%**					**37.4%**

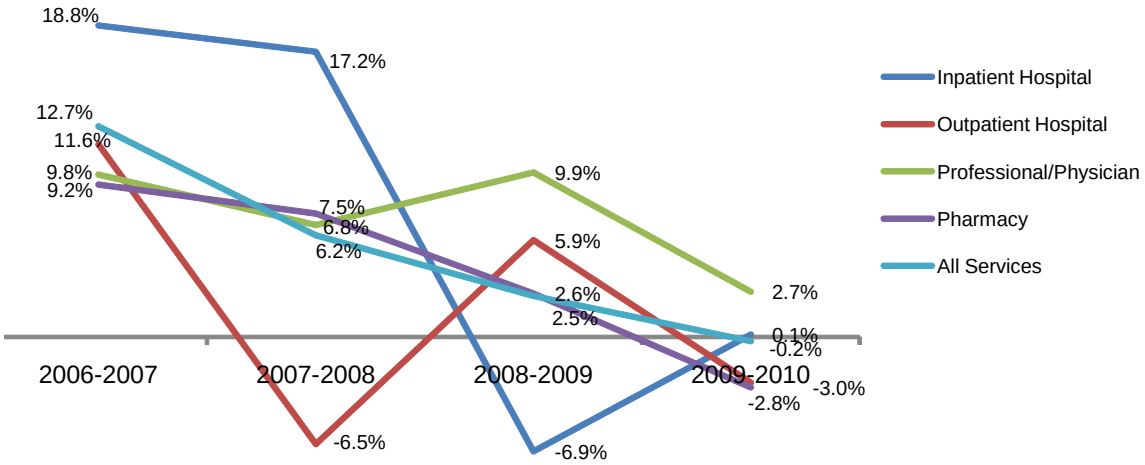
NOTES:

1. *Defined as the unique count of the concatenation of member rhn, provider id, and discharge date for Inpatient Hospital and the unique count of the concatenation of member rhn, provider id, and date of services for all other services.*
2. *With the exception of Inpatient Hospital and Pharmacy, units includes visits as well as any ancillary services rendered during a visit/encounter.   For Inpatient Hospital, units equals the number of days. For Pharmacy, units equals the number of scripts.*
3. *Calculation: (Cost PMPM * 12000) / Adm per 1000*
4. *Calculation: (Cost PMPM * 12000) / Units per 1000*
5. *Excludes IBNR (costs for claims incurred but not reported/received).*
6. *A negative variance indicates a decrease from one calendar year to the next, while a positive variance indicates an increase from one calendar year to the next.*
7. *Defined as any claim tracking to service category code 100 (Facility Inpatient). Based off of discharge date.*
8. *Defined as any claim tracking to service category code 200 (Facility Outpatient) or service category code 400 (Ancillary) with a claim type of U (UB). Based off of date of service.*
9. *Defined as any claim tracking to service category code 300 (Professional Services) or service category code 400 (Ancillary) with a claim type of H (HCFA). Based off of date of service.*
10. *Defined as any claim tracking in the Rx Data Table in NWHCONN-BETA Datawarehouse.*
11. *Defined as any Dental or Vision claim.*
12. *Defined as the sum of Inpatient Hospital Adm per 1000, Outpatient Hospital Adm per 1000, Professional/Physician Units per 1000, Pharmacy Units per 1000, and All Other Claims Units per 1000.*
13. *Calculation: (Total PMPM * 12000) / Total Utilization per 1000*

Network Health Commonwealth Care -- Forward
Annual Growth Expenditures per Member by Major Type of Service



Network Health Mass Health -- Together
Annual Growth Expenditures per Member by Major Type of Service



Network Health Consolidated
Annual Growth Expenditures per Member by Major Type of Service